

State IllinoisMETHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPE OF CARE - BASIS FOR  
REIMBURSEMENT*Amendment to Plan Not Approved / Amendment to Plan Not Disapproved*10/92 1. Reimbursement for Hospital Outpatient and Clinic Services

## a. Fee-For-Service Reimbursement

07/98 i. Reimbursement for hospital outpatient shall be made on a fee-for-service basis except for:

07/98 A. Those services that meet the definition of the Ambulatory Procedure Listing (APL) as described in subsection .b. of this Section;

07/98 B. End Stage Renal Disease Treatment (ESRDT) services, as described in subsection .c. of this Section;

07/98 C Those services provided by a Critical Clinic Provider as described in subsection .e. of this Section.

07/99 ii. Fee-for-service Except for the procedures under the APL groupings described in subsection (b) of this Section, fee-for-service reimbursement levels shall be at the lower of the hospital's usual and customary charge to the public or the Department's statewide maximum reimbursement screens, as described in the annual obstetric and pediatric State plan. Hospitals will be required to bill the Department utilizing specific service codes. However, all specific client coverage policies (relating to client eligibility and scope of services available to those clients) which pertain to the service billed are applicable to hospitals in the same manner as non-hospital providers who bill fee-for-service.*Amendment to Plan Not Approved / Amendment to Plan Not Disapproved*TN # 99-04  
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10/92 1. Reimbursement for Hospital Outpatient and Clinic Services

a. Fee-For-Service Reimbursement

- 07/98 i. Reimbursement for hospital outpatient and hospital-based clinic services shall be made on a fee-for-service basis except for the following services for which reimbursement is otherwise defined in this attachment:
- 07/98 A. Those services that meet the definition of the Ambulatory Procedure Listing (APL) Hospital Ambulatory Care program as described in subsection b. of this Section; which shall be reimbursed in accordance with hospital ambulatory care reimbursement methodology, with rate adjustments as defined in this section; and
- 07/98 B. End Stage Renal Disease Dialysis Treatment (ESRDT) services, as described in subsection c. of this Section; shall be reimbursed and adjusted in accordance with this section;;
- ~~07/98 C. Those services provided by a Certified Pediatric Ambulatory Care Center (CPACC), as described in subsection e.iii.;~~
- 07/98 ~~D-C~~ Those services provided by a Critical Clinic Provider as described in subsection e. of this Section.
- ii. Fee-for-service reimbursement levels shall be at the lower of the hospital's usual and customary charge to the public or the Department's statewide maximum reimbursement screens, as described in the annual obstetric and pediatric State plan. Hospitals will be required to bill the Department utilizing specific service codes. However, all specific client coverage policies (relating to client eligibility and scope of services available to those clients) which pertain to the service billed are applicable to hospitals in the same manner as non-hospital providers who bill fee-for-service.

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- 04/93      iii.      With respect to Illinois county-owned encounter rate hospitals as defined in Appendix to Attachment 3.1-A and 3.1-B, the reimbursement rate described above shall be adjusted on a retrospective basis. The retrospective adjustment shall be calculated as follows:
- 04/93      A.      The reimbursement rates described above shall be no less than the reimbursement rates in effect on June 1, 1992, except that this minimum shall be adjusted on the first day of July of each year by the annual percentage change in the per diem cost of inpatient hospital services as reported on the two most recent annual Medicaid cost reports.
- B.      The per diem cost of inpatient hospital services shall be calculated by dividing the total allowable Medicaid costs by the total allowable Medicaid days.
- 7/95      iv.      Enhanced rates as described in the annual obstetric and pediatric State plan shall be paid to CHAPCCs, CHOSCs, COBACCs and CPACCs. The enhanced rates are effective for services provided in MCH clinics on or after April 1, 1993.
- 07/93      v.      County-owned and State-owned hospitals shall be required to submit outpatient cost reports to the Department within 90 days of the close of the facility's fiscal year.
- 07/93      vi.      With the exception of the retrospective adjustment described above, no year-end reconciliation is made to the reimbursement rates calculated under this Section.
- 07/98      b.      Ambulatory Procedure Listing (APL) Hospital Ambulatory Care Program

Effective July 1, 1998, the Department will reimburse hospitals, for certain hospital outpatient procedures as described in b.1. of this Section ~~Effective April 1, 1986, the Department liberalized the list of allowable ambulatory procedures to add many surgical, diagnostic and highly technical treatment procedures that can be performed and reimbursed on an ambulatory basis.~~

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07/98 i. APL-Hospital Ambulatory Care Groupings

Under the ~~APL Hospital Ambulatory Care Program~~, a ~~Hospital Ambulatory Care~~ list was developed that defines those technical procedures that require the use of the hospital outpatient or ~~hospital-based clinic~~ setting, its technical staff and/or equipment. These procedures ~~are~~ were separated into ~~four~~ separate groupings based upon the complexity and historical costs of the procedures. The ~~four separate~~ groupings are as follows:

07/98 A. Surgical Groups ~~Group 1 procedures are high-level technology surgeries that consume many hospital resources and are costly to deliver.~~

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1. Surgical group 1.a. consists of intense surgical procedures. Group 1 .a. surgeries require an operating suite with continuous patient monitoring by anesthesia personnel. This level of service involves advanced specialized skills and highly technical operating room personnel using high technology equipment.
2. Surgical group 1.b. consists of moderately intense surgical procedures. Group 1.b. surgeries generally require the use of an operating room suite or an emergency room treatment suite, along with continuous monitoring by anesthesia personnel and some specialized equipment.
3. Surgical group 1.c. consists of low intensity surgical procedures. Group 1.c. surgeries may be done in an operating suite or an emergency room and require relatively brief operating times. Such procedures may be performed for evaluation or diagnostic reasons
4. Surgical group 1.d. consists of surgical procedures of very low intensity. Group 1.d. surgeries may be done in an operating room or emergency room, have a low risk of complications, and include some physician-administered diagnostic and therapeutic procedures.

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- 07/98                      B.      ~~Diagnostic and Therapeutic Groups Group II procedures are certain nonsurgical, very high level technology services recognized and approved by the Department as safe outpatient procedures~~
1.      Diagnostic and therapeutic group 2.a. consists of advanced or evolving technologically complex diagnostic or therapeutic procedures. Group 2.a. procedures are typically invasive and must be administered by a physician
  2.      Diagnostic and therapeutic group 2.b. consists of technologically complex diagnostic and therapeutic procedures that are typically non-invasive. Group 2.b. procedures typically include radiological consultation or a diagnostic study.
  3.      Diagnostic and therapeutic group 2.c. consists of other diagnostic tests. Group 2.c. procedures are generally non-invasive and may be administered by a technician and monitored by a physician.
  4.      Diagnostic and therapeutic group 2.d. consists of therapeutic procedures. Group 2.d. procedures typically involve parenterally administered therapeutic agents. Either a nurse or a physician is likely to perform such procedures.
- 07/98                      C.      ~~Group III procedures are other surgical, specialized cardiac and diagnostic procedures:~~  
Group 3 includes reimbursement for services provided in a hospital emergency department that will be made in accordance with one of the three levels described below. Emergency Services mean those services which are for a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, possessing an average knowledge of medicine and health could reasonably expect that the absence of immediate attention would result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions

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or serious dysfunction of any bodily organ part. The determination of the level of service reimbursable by the Department shall be based upon the circumstances at the time of the initial examination, not upon the final determination of the client's actual condition, unless the actual condition is more severe.

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1. Emergency Level I refers to Emergency Services provided in the hospital's emergency department for the alleviation of severe pain or for immediate diagnosis or treatment of conditions or injuries which pose an immediate significant threat to life or physiologic function.

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2. Emergency Level II refers to Emergency Services that do not meet the above definition of Emergency Level I care, but which are provided in the hospital emergency department for a medical condition manifesting itself by acute symptoms of sufficient severity.

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3. Non-Emergency/Screening Level means those services provided in the hospital emergency department that do not meet the requirements of Emergency Levels I or II stated above. For such care, the Department will reimburse the hospital has a choice to bill the Department either the applicable current FFS rates for the services provided or a screening fee, but not both. The rate for the screening fee is based on periodic negotiations with representatives of the hospital industry. The reimbursement rate for the screening fee will be the same as the current applicable rate for procedure code 99282 (emergency department visit, as specified in the Physicians Current Procedural Terminology, fourth edition [CPT-4]).

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D.

Group 4 for observation services is established to reimburse such services that are provided when a patient's current condition does not warrant an inpatient admission but does require an extended period of observation in order to evaluate and treat the patient in a setting which provides ancillary resources for diagnosis or treatment with appropriate medical and skilled nursing care. The hospital may bill for both observation and other APL procedures but will be reimbursed only for the procedure (group) with the highest reimbursement rate. Observation services will be reimbursed under one of three categories: at least one hour but less than six hours and thirty-one minutes of services; at least six hours and thirty-one minutes but less than twelve hours and thirty-one minutes of services; or, twelve hours and thirty-one minutes of services or more.

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E.

Group 5 for psychiatric treatment services is established to reimburse for certain outpatient treatment psychiatric services that are provided by a hospital that is enrolled with the Department to provide inpatient psychiatric services. Under this group, the Department will reimburse Type A and Type B Psychiatric Clinic Services, at different rates, as defined in the Illinois Administrative Code at 89 Ill. Adm. Code Section 148.40.d.2. and the Illinois Medicaid State Plan.

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F.

Group 6 for physical rehabilitation services is established to reimburse for certain outpatient physical rehabilitation services. Under this group, the Department will reimburse for services provided by a general care hospital not enrolled with the Department to provide inpatient physical rehabilitation services at a different rate than will be reimbursed for physical rehabilitation services provided by a hospital that is enrolled with the Department that provides specialized physical rehabilitation services. The rate for such services is based on periodic negotiations with representatives of the hospital industry. ~~that are provided by a hospital that is enrolled with the Department to provide inpatient physical rehabilitation services.~~

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ii. Each of the groups above will be reimbursed by the Department considering the following:

A. ~~With the exception of county-owned hospitals located in an Illinois county with a population greater than three million, reimbursement rates for each of the reimbursement groups described above shall be the lesser of:~~

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1. ~~the hospital's charge to the general public, or~~

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2. ~~rates established by the Department.~~

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A) Effective October 1, 1999, the Department will provide cost outlier payments for specific devices and drugs associated with specific APL procedures. Such payments will be made if:

1) The device or drug is included on an approved list maintained by the Department and published in the Hospital Provider Handbook. In order to be included on the Department's list, the Department will consider requests from medical providers and shall base its decision on medical appropriateness of the device or drug and the costs of such device or drug; and

2) The provision of such devices or drugs is deemed to be medically appropriate for a specific client, as determined by the Department's physician consultants.

B) Additional payment for such devices or drugs, as described in subsection 1.b.ii.A. of this Section, will require prior authorization by the Department unless it is determined by the Department's professional medical staff that prior authorization is not warranted for a specific device or drug.

C) The amount of additional payment for devices or drugs, as described in subsection 1.b.ii.A. of this Section, will be based on the following methodology:

1) The product of a cost to charge ratio that, in the case of cost reporting hospitals, or in the case of other non-cost reporting providers, equals 0.5, multiplied by the provider's total covered charges on the qualifying claim, less the APL payment rate multiplied by four;

2) If the result of subsection 1.b.ii.C.1. above is less than or equal to zero, no cost outlier will be made. If the result is greater than zero, the additional payment will equal the result of subsection 1.b.ii.C.1. above, multiplied by 80 percent. In such cases, the provider will receive the sum of the APL payment and the additional payment for such high cost devices or drugs.

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BD. APL rates established by the Department will be based on the relative weighting of each reimbursement grouping. The relative weighting of each group will be based on the resource intensity required to provide service described under each group. Classifications of procedures into APL groups will be reviewed annually and relative weighting will be updated periodically.

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GE.

For county-owned hospitals located in an Illinois county with a population greater than three million, reimbursement rates for each of the reimbursement groups shall be specified by the Department. However, such rates shall be no lower than the rates in effect on June 1, 1992, except that this minimum shall be adjusted on the first day of July of each year by the annual percentage change in the per diem cost of inpatient hospital services as reported on the two most recent annual Medicaid cost reports. The per diem cost of inpatient hospital services is calculated by dividing the total allowable Medicaid costs by the total allowable Medicaid days.

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~~The rate for each group is all-inclusive for services provided by the hospital.~~ Reimbursement for each APL group described in subsection b.i. shall be all-inclusive for all services provided by the hospital, regardless of the amount charged by a hospital. No separate reimbursement will be made for ancillary services or the services of hospital personnel. ~~The one exception is~~ Exceptions to this provision are that hospitals shall be allowed to bill separately, on a fee-for-service basis, for professional outpatient services of a physician physicians providing direct patient care who is are salaried by the hospital, and occupational or speech therapy services provided in conjunction with rehabilitation services as described in subsection .b.i. of this Section who provide emergency Level I or II services in the emergency department. For the purposes of this Section, a salaried physician is a physician who is salaried by the hospital; a physician who is reimbursed by the hospital through a contractual arrangement to provide direct patient care; or a group of physicians with a financial contract to provide emergency department care. Under APL reimbursement, salaried physicians do not include radiologists, pathologists, nurse practitioners, or certified registered nurse anesthetists and no separate reimbursement will be allowed for such providers.

E.G

The Department of Public Aid will reimburse ambulatory surgical treatment centers (ASTCs) for facility services in accordance with covered APL groups as defined in this section. The Department may exclude from coverage in an ASTC any procedure identified as only appropriate for coverage in a hospital setting. All groups that may be reimbursed to an ASCT are defined in the Department's hospital handbook and notices to providers. Reimbursement levels shall be the lower of the ASTC's usual and customary charge to the public or an all inclusive rate for facility services, which shall be 75 percent of the applicable APL rate.

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1. Facility services furnished by an ASTC in connection with covered APL codes include, but are not limited to:
  - a. Nursing, technician and related services;
  - b. Use of the ASTC facilities;
  - c. Supplies (such as drugs, biologicals (e.g., blood), surgical dressings, splints, casts and appliances, and equipment directly related to the provision of surgical procedures;
  - d. Diagnostic or therapeutic services or items directly related to the provision of a surgical procedure;
  - e. Administrative, record keeping, and housekeeping items and services; and
  - f. Materials for anesthesia.
2. Facility services do not include items and services for which payment may be made under other provisions of this Section such as physicians' services, laboratory, x-ray or diagnostic procedures performed by independent facilities or practitioners on the day of surgery (other than those directly related to performance of the surgical procedure), prosthetic devices, ambulance services, leg, arm, back and neck braces, artificial limbs, and durable medical equipment for use in the patient's home. In addition, they do not include anesthetist services.
- iii. The assignment of procedure codes to each of the reimbursement groups in subsection b.i. of this Section are detailed in the Department's Hospital Handbook and in notices to providers.

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